insurers of those responsible for road traffic accidents. The total cost to the NHS for road traffic injuries is about £90m per annum however, and Oxford Regional Health Authority has apparently been tempted to offload the entire expense of accidental injuries on to private insurance. Those who parachute for sport, rock-climb or motor-race could, according to this philosophy, find themselves without State health care in the event of accidental injury. This would be a major reversal of policy since in the past, we have always tried to encourage young people to overcome fear, and have successfully channelled man's inherent aggression for the benefit of society. But accidental injury in this context is no less self-inflicted than the smoker's lung cancer, and the example illustrates well the tension between individual freedom and personal responsibility in societies in which the State has taken over health care. The slippery slope of personal responsibility can take us still further if we think for a moment. Are those with hereditary diseases such as haemophilia, muscular dystrophy or sickle cell disease to be forced to accept compulsory sterilisation and abortion, or otherwise to bear the enormous additional cost of looking after the affected children themselves? Most people could not accept such a development and would say this removed any right we might have to call ourselves a caring society.

The political aspects of compulsory health and safety will continue to pose problems until health care is seen to be receiving a higher priority for national resources. In addition, the current budget of the Health Education Council is sadly inadequate, and governments will have to adopt a less hypocritical attitude towards health education, exemplified so blatantly with respect to tobacco advertising and the lack of government compensation for children brain damaged as a result of vaccination. Alternatives to health education are all subject to serious objections, and the time has come to debate what principles should apply to the decision-making process. A fair system which does not penalise the poorest members of society and which does not victimise people because of religion, race or inheritance must be the basis for this debate. In addition, the progressive loss of individual freedom of choice must be given much more consideration.

Compulsory health and safety is a very dangerous notion which may only be justifiable when the public *health* interest and not its *economic* interest is at stake. Sickness and death come to both the fit and the frail eventually, and few would admire the obsessive pursuit of fitness and health so humorously portrayed by Stephen Leacock in How to Live to be 200 (1). A health service based on personal culpability is neither a sound nor a Christian ideal, but the gradual erosion of individual freedom, by a State which finds itself increasingly unable to keep pace with the cost of modern medicine, is no less a grim prospect.

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Commentary

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I should like to comment on the concept of compulsion as it occurs in Dr Boughton's interesting discussion. As he rightly says, compulsion requires justification and the only consistent justification within the liberal tradition of J S Mill is that one's activities are harming others. Compulsion on the grounds that it is for our own good constitutes 'sterile paternalism', which Dr Boughton regards as characteristic of totalitarian societies.

But even within the liberal tradition the associated ideas of 'harm to others' and 'compulsion' are not without problems, empirical, procedural and conceptual. Take, for example, the case of tobacco. (Dr Boughton discusses the problems of alcohol at the same time, but since I think alcohol raises slightly different problems I shall confine myself for brevity to tobacco). Dr Boughton points out that 'those who inflict lung cancer upon themselves have already paid additional taxes', and that 'it would not only be puritanical but also highly counter-productive to attempt to ban . . . tobacco'. An empirical point complicating this concerns the way in which tobacco-related diseases are transmitted. If it is true that *your* smoking can harm *my* lungs then, granted the many ways in daily life in which your smoke may enter my lungs, there is justification, if not for restricting your smoking as such, at least for greatly restricting the *public places* in which you are allowed to smoke. Moreover, restrictions on smoking are 'puritanical' only to those who enjoy smoking. Leaving aside the question of health, we can still point out that an increasing number of people *dislike* the smell of smoke, the way in which it clings to the clothes of the non-smoker etc. Now, if it is an empirical fact that many people dislike smoke, then the freedom and enjoyment of smokers in public places is at the expense of the freedom and enjoyment of the non-smoker, and it is not therefore 'puritanical' to try to curb smokers.

But even granted that smoking might interfere with the pleasure of non-smokers, and might even harm

them, there is still the question which Dr Boughton raises of the *procedures* which it is expedient or even morally permissible to use to curb it (and similar activities). Dr Boughton notes that legislation can be counter-productive and that education is sometimes more effective. This is true, and one could add here that even were it the case that legislation might sometimes be effective there is still the question as to whether there can be too high a price to pay for the enforcement of principles which might in themselves be desirable expressions of liberalism. Switzerland is sometimes mentioned as a country in which the enforcement of morally desirable principles has produced an undesirable social atmosphere. The general point is that liberalism is not simply about what ought or ought not to be enforced but also, as Dr Boughton illustrates, about ways of proceeding to convince people by education and example (many doctors and nurses smoke and drink heavily) as to how they ought to behave towards others.

The *conceptual* question of what constitutes harm to others is brought out in a sharp way by one of Dr Boughton's main conclusions, that 'compulsory health and safety is a very dangerous notion which may only be justifiable when the public *health* interest, and not its *economic* interest is at stake'. But is it not true that a person or a State is harmed when resources which might otherwise be used on education, housing, the arts . . . are directed to finance the consequences of avoidable self-indulgence? An answer to this question turns on a philosophical analysis of the concept of harm, as we can see if we examine another tradition which has a different approach to 'harm' and 'compulsion' – collective socialism.

We tend to think of collective socialism in terms of the Soviet or Chinese varieties, but in fact there is a native English variety which goes back to the Levellers of the seventeenth century. Indeed, the origins of this form of socialism are to be found in Christianity, which tells us that we are 'members one of another'. Whereas the tradition of liberalism stresses freedom and the satisfaction of individual wants, the tradition of socialism stresses fraternity and the satisfaction of individual needs. It is this second tradition which led to the setting-up of the Welfare State. The idea behind the Welfare State is that a person's health, education, old age, and so on are too important to be left to the cut-and-thrust of market competition or charity, and that the State should therefore provide a system more or less free to all but paid for by graduated taxation. The slogan here is: from each according to his ability, to each according to his need. It was assumed by the pioneers of the Welfare State that it could be grafted on to the liberal tradition and that economically and morally we could have the best of individualism and socialism. It is this assumption that creates the problem of the right to be unhealthy. The problem arises when, in terms of one tradition, we are sympathetic to the right to be unhealthy and, in terms of the other, we have a duty to care for the unhealth of others, where 'care for' means 'pay for through heavy taxation'.

Within the tradition of collective socialism the terms 'compulsion' and 'freedom' take on a different aspect. Firstly, the sharp distinction in liberalism between your self and its freedom and my self and its freedom is minimised; we are 'members one of another'. Secondly, the State is not something alien to the self and its essential freedom, but rather the laws of the State are an expression of the self; as Rousseau puts it, they force us to be free. (Again, there are Christian antecedents for this view – 'In Thy service is perfect freedom'.) What for the liberal is State 'compulsion' or 'sterile paternalism' constitutes for the socialist an expression of his true social self.

The theoretical confusions we can find ourselves in are due to the fact that we are almost as much influenced by the collectivist ideas of Christian socialism as we are by the idea of liberal individualism. Nor do I advocate any attempt to impose consistency in the practicalities of the moral and political sphere. It is preferable to take each issue as it comes – seat belts, fluoride, boxing . . . on a pragmatic basis. And if a preference for the muddle of piecemeal social engineering over the consistency and purity of political doctrine of the Right or the Left is still liberalism, then so be it.

(Continued from page 172)

(6) Williams B. *Moral luck*. Cambridge: Cambridge University Pfess, 1981: 49.
(7) MacIntyre A. *After virtue – a study in moral theory*. London: Duckworth, 1981: 216.
(8) See reference (5) 265–268, for an indication of how such compatibility can be construed.
(9) See for example Crisp A H. Selection of medical students – is intelligence enough? A discussion paper. *Journal of the Royal Society of Medicine* 1984; 77: 35–39, and the authors he cites for advocacy of a wide range of medical virtues. For (a these days uncommon) advocacy of humility as a medical virtue see Pappworth M H. *A primer of medicine*. (3rd ed.). London: Butterworth, 1971: 31 and Linzer M. Doing what 'needs' to be done. *New England Journal of Medicine* 1984; 310: 469–470. For a brief non-medical account of the medical virtues see May W F in: Callahan D, Bok S, eds. *Ethics teaching in higher education*. Hastings on Hudson: Hastings Centre, 1980: 230–233.